



## King's Research Portal

DOI:

[10.1192/bja.2018.30](https://doi.org/10.1192/bja.2018.30)

*Document Version*

Peer reviewed version

[Link to publication record in King's Research Portal](#)

*Citation for published version (APA):*

McCormack, D., & Chalder, T. (2018). Horses for courses: choosing an evidence based psychological therapy for your patient. *BJPsych Advances*. <https://doi.org/10.1192/bja.2018.30>

### **Citing this paper**

Please note that where the full-text provided on King's Research Portal is the Author Accepted Manuscript or Post-Print version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version for pagination, volume/issue, and date of publication details. And where the final published version is provided on the Research Portal, if citing you are again advised to check the publisher's website for any subsequent corrections.

### **General rights**

Copyright and moral rights for the publications made accessible in the Research Portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognize and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the Research Portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the Research Portal

### **Take down policy**

If you believe that this document breaches copyright please contact [librarypure@kcl.ac.uk](mailto:librarypure@kcl.ac.uk) providing details, and we will remove access to the work immediately and investigate your claim.

# **Horses for courses: choosing an evidence based psychological therapy for your patient**

## **KEYWORDS:**

*Psychological therapy, cognitive behaviour therapy, systemic therapy, psychoanalysis, psychodynamic therapy, transdiagnostic, common factors, choosing therapy*

Authors

Dr David McCormack, The Maudsley Hospital, South London and Maudsley NHS Foundation Trust.

&

Professor Trudie Chalder, Institute of Psychiatry, Psychology and Neuroscience, King's College London.

*Word count: 4857 excluding references*

## *Declaration of transparency:*

*Professor Chalder receives salary support from the National Institute for Health Research (NIHR) Mental Health Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King's College London. Dr McCormack works on research trials funded by the Guy's and St Thomas' Charity. The views expressed in this article are those of the authors and not necessarily those of the NIHR or the NHS.*

## **Abstract**

Choosing an intervention for a patient experiencing distressing symptoms and/or suffering with a mental disorder is part of routine practice for clinicians. While there are now many effective pharmacological and psychological therapies for mental health problems, syndromes and persistent physical symptoms (e.g. chronic pain), choosing the ‘right’ therapy can sometimes be a challenge. This can certainly be the case when it comes to psychological therapies. There are many different approaches to choose from and many have not been subjected to rigorous study.

In this paper, we aim to help inform and guide the busy clinician in choosing a psychological therapy for their patient. We aim to achieve this goal by, (1) providing a brief overview of the major psychotherapy modalities, (2) considering which guidelines to refer to and which psychological therapies have been found to be most effective for the presenting problem(s) seen in clinic. And lastly, (3) we will discuss the limitations of the current guidelines when it comes to co-morbid presentations and consider how this can be best addressed.

## **Introduction**

Pioneering work by Janet (1901) and Breuer and Freud (1895) demonstrated that non-invasive treatment (i.e. ‘talking therapy’) could enable patients to overcome emotional and psychological disturbance. Following on from the work of these early pioneers there has been considerable progress in our understanding of what maintains common mental health conditions and syndromes, and how psychological therapies can help to treat such

difficulties. Progress, during the twentieth century, was made possible by advances in areas, such as, behavioural and cognitive psychology, refinement of psychoanalytic theory, existential philosophy, and the development of cybernetics and systems theory as applied to human psychology. As a result of this fertile period of development we now have many forms of psychotherapy, from arts therapies through to Zen therapy. Of these many and varied approaches a smaller number have been well developed and subjected to rigorous empirical study. In this article, we limit our focus to the major modalities.

Broadly speaking, we can classify psychotherapy into four major modalities,

- (1) Psychoanalytic/psychodynamic
- (2) Cognitive and behavioural
- (3) Humanistic and existential
- (4) Systemic

Each of these modalities should not be considered as representing a single therapeutic approach but rather a broad movement of therapies which have commonalities in regard to philosophical and theoretical underpinnings and/or therapeutic methods, techniques and strategies. To better understand these modalities, we will briefly summarise the approaches and then guide the reader on which guidelines to refer to when choosing an effective psychological therapy for their patients. After this we will consider some of the challenges that can occur when using the current guidelines and consider ways to address this.

### **Psychoanalytic and psychodynamic**

The psychoanalytic modality is a very broad and diverse movement of theories and approaches, ranging from, psychosexual and psychosocial formulations through to object relations and attachment theories. It is challenging to concisely summarise what unites these diverse approaches. What arguably is at the heart of the many sophisticated theories and nuanced accounts of the human condition and psychopathology postulated under this broad umbrella of approaches is the seemingly simple idea, that early experiences affect the developing intrapsychic world and that this subsequently influences and colours the experiences and behaviours of the present self. In a real and profound sense, the past is thought to influence the present. As human development is by its nature incremental, it occurs over a lifetime, and as much of mental life is unconscious, out of our awareness, it is arguable that the past, and moreover unconscious representations derived from past experiences, influence the present in terms of both ones internal world and external behaviour (Bateman & Holmes 2002).

Treatment varies depending on the school of thought a therapist has been trained in and/or is working from (Gabbard, 2007). In general, during the course of therapy the therapist works together with the patient to enable them to explore and become conscious of what is contributing to their emotional responses and behaviours. Therapy may involve working towards resolving unconscious conflicts. To do this the therapist uses a number of methods and often can include exploring the patient's transference to them. Transference is an intrapsychic phenomenon in which the patient transfers to the therapist, or someone important in their present life, the "conflict laden ideas and feelings that are more appropriate to someone important in the persons past" (Patton *et al*, 1992: p85). The

therapist may use transference, as well as countertransference (i.e. feelings evoked in the therapist), as a way to gain insight into the patient's internal world and to uncover how the patient relates with significant others in their life. By the therapist sensitively interpreting for the patient the transference that is taking place, this may provide the patient an opportunity to become aware of their unconscious internal world and patterns of relating to others (Freud 1910).

This process, of helping the patient make sense of how they feel, respond, and interact with other people the way that they do, is a complex one. It is all too easy for the patient to resist the process, and for example, respond with primitive defences, and/or seize upon something inconsequential to explain their feelings and behaviours. There are many reasons a patient may not want to explore and search for the unknown unconscious 'content' for distressing feelings and behaviours, these include, painful memories, recognising difficulties in past and current relationships, and potentially confronting the 'negative' side of personality, the sum of all those qualities we like to hide, that we are afraid of; the hated or feared parts of ourselves (Klein 1984)

An important aspect of modern psychoanalytic/psychodynamic therapy is that it aims to facilitate an empathic containing therapeutic relationship (Bion 1962), where attachment is considered not only in terms of the patients past but also how it plays out in the consulting room (Ma 2006). Therapy provides an environment where the person can make sense of why they react the way they do, process distressing memories and experiences, and better understand themselves and their relationship with others, which may lead to an improved

integration of the self, where the person is less distressed and/or is better able to understand and tolerate such feelings.

### **Cognitive and behavioural**

To understand the modern cognitive and behavioural approach it is useful to know a little about where its roots stem from. To do this it is important to firstly note that the cognitive and behavioural approach encompasses a broad umbrella of theories and therapies, it is not one discrete approach. In fact, prior to the development of the cognitive approach there was simply behaviour therapy. The origins of behaviour therapy stemmed from experimental psychology and physiology. Building on the findings of Pavlov (1927) and Watson and Rayner (1920) experimental research quickly led to clinical application. Mowrer (1947) drawing on classical and operant conditioning theory developed empirical formulations that cemented the foundations of behavioural therapy. For example, providing an elegant theory of why fear persists and does not simply fade and extinguish. Within this framework it is argued that when people develop a fear they seek to avoid experiencing the unpleasant feeling, and through avoidance the *conditioned response* (i.e. fear) does not naturally extinguish and is maintained. Wolpe (1968) advanced the idea of developing a hierarchy of feared situations and using systematic desensitization paved the way to enable people to overcome their anxiety and fears through the use of exposure. That is, through exposure to the feared stimuli over time the fear/anxiety fades (i.e. the *conditioned response* extinguishes). After this, further refinements to behavioural therapy were developed and it has successfully been applied to treat a range of clinical problems.

As behavioural therapy began to be applied to a wide range of clinical problems it became apparent to many that a strictly behavioural approach was missing an important component, namely, it was overlooking the role of mental processes. Work by figures such as Ellis (1962) and Beck (1976, 1993), emphasized that cognitive processes played an important role in the development and maintenance of emotional disorders, and that therapy focused on cognitive factors, for instance, challenging unhelpful thinking (e.g. excessively negative thoughts, cognitive distortions etc.), could bring about behavioural change and symptom improvement. The adoption of the cognitive approach provided a dynamism that had been lacking before. This can be expressed simply in the following circular process - cognitive change influences behaviour, behaviour influences cognition, and they both affect emotions and physiology, which in turn influence cognition and behaviour. The combination of both cognitive and behavioural components has enabled the development of sophisticated formulations and treatments for a wide range of mental disorders, unexplained and persistent physical symptoms, and long-term conditions.

At the heart of the cognitive behavioural approach is an empirical focus. The experimental roots of this approach carry through into the consulting room. This occurs by routinely subjecting the approach to rigorous monitoring and scrutiny even at the level of individual therapy. For example, complex idiosyncratic formulations (i.e. a theoretical model of the patient's problems) are developed collaboratively with the patient and draw on, in large part, findings from empirical research. This shared formulation seeks to make sense of the patient's difficulties and will guide where and how to intervene. A cognitive behavioural formulation is designed to be testable. That is, it enables a clear framework for the patient



to test if the intervention, the cognitive and behavioural strategies and techniques, are effective in overcoming the presenting problem(s) and in achieving treatment goals (e.g. improvement in symptoms, reducing associated distress, increasing functioning etc.).

### **Humanistic and existential approaches**

Humanistic and existential approaches are another broad grouping of therapies. The roots here can be traced back to continental philosophy. Humanistic therapy assumes quite an optimistic view of the human condition, one where people are naturally striving towards growth, fulfilment, and actualization; therapy within this approach aims to remove barriers to this growth and enable the person to move towards self-actualisation. An underlying assumption of this approach is that human beings have an inbuilt propensity towards self-realization (Horney 1999) and that with the right environment, the right conditions, the person can surmount their difficulties, and grow and develop as a person. Therapy within this approach seeks to provide these conditions. That is, the patient by being accurately empathized with, listened to with unconditional positive regard by a therapist who is being genuine and congruent, provides the necessary conditions for the person to discover for themselves how to overcome their difficulties and develop (Rogers 1951). While the conditions for therapy that Rogers describes within this approach is likely important to foster a good therapeutic relationship, that these conditions are considered sufficient for effective therapeutic change is not as well supported.

Existential approaches in contrast to the humanistic approach are often seen as being more firmly rooted in weighty philosophical origins, and that they are more concerned with

ontological and ontic inquiry, a search for meaning, and take a more nuanced view of the human condition. However, while there is indeed some truth to this, particularly in regards to the British school (Spinelli 2014), the focus on supporting people to non-judgmentally examine the view they hold of themselves, of life, their relationship with others, and the narratives and meanings they construct, have many parallels and similarities with humanistic approaches, perhaps not surprising given their shared philosophical roots.

Both humanistic and existential therapies place an emphasis on meaning and subjective experience, and seek to explore with the patient their unique experience of being-in-the-world. Therapy from these approaches amongst other things aims to support people to take responsibility for making their own choices and choosing how they want to act. These are approaches not fixated with strategies and techniques, which are a common feature of other approaches (e.g. cognitive behavioural therapy). And while they are insight orientated therapies, in contrast to psychoanalytic approaches, interpretation is de-emphasised and subjective exploration is arguably given even greater emphasis, and it is through this process of explorative enquiry that leads to fresh insight, and with it the freedom for the person to choose how they will respond and act in light of this insight.

### **Systemic approaches**

While the other psychotherapy approaches presented here have many differences, some explicitly obvious and others more nuanced, what they share in common is a focus on the individual. They often seek to understand the person's symptoms and problems as arising from within the individual, for example, as a result of psychological processes and/or

because of unhelpful behaviours, and interventions tend to focus on working with the individual patient to address their difficulties. Systemic approaches can be seen to stand in contrast to these other psychotherapy approaches presented here. Some consider systemic and family therapy approaches to be radically different (Stratton 2011). Rather than focusing solely on the individual such approaches take a wider focus. From a systems perspective, the individual is viewed to be affected by the setting and contexts, the systems, they find themselves in. The individual is seen as affected by their relationship and interaction with others in the systems they are in, and they also affect the other individuals in these systems.

Some theorists have even postulated that the symptoms an individual experiences may arise from how other people interact with the individual and/or that certain types of systems, specifically certain families, are associated with certain disorders, for example, ‘psychosomatic families’ (Minuchin *et al* 1978). However, there is little to no empirical evidence to support this. Most modern systemic theory and family therapy typically allows for the possibility that the original problem may have arisen for any number of reasons but it can be maintained or exacerbated by how those in the system interact with one another, and these interactions are assumed to be driven by a range of beliefs and narratives held by those in the system.

Systemic intervention is most often carried out with families and couples but it has even been adapted to work with individuals by supporting the individual to become more aware of the wider social context and their relationships with others in various family and social

systems (Jenkins & Asen 1992). While there are many forms of systemic and family therapy approaches, a key feature is supporting individuals in the system to better understand how they relate to one another, to deemphasise the focus on pathology and/or blaming one particular person (i.e. the identified patient), and then drawing on this understanding to enable those in the system to improve their way of relating to one another, and as ways of relating improve it is assumed that this will address the presenting problem (e.g. in the case of disturbing symptoms experienced by a member of a family, these should fade or become less problematic) (Carr 2008).

### **Similarities - the major modalities**

While it is clear that there are many differences across the major modalities there are similarities too. For instance, it is now widely accepted that an individual's experience, from the earliest moments onwards affects how one thinks and acts, relates to others and how one is treated. Attachment theory has influenced the major schools of therapy, Even if it's not always explicitly referenced the influence of this theory is present in many modern formulations which seek to understand the patients past relationships and their current ones, including the relationship in the consulting room (Ma 2006). There is also a growing appreciation of the role of unconscious processes across the psychotherapy modalities, although here considerable diversity exists regarding the conceptualisation of the unconscious and its role in therapy (e.g. Power & Brewin 1991; Flaskas 2005).

Systemic elements are either implicitly or explicitly acknowledged and incorporated into theory across the modalities. That is, even in the therapies which predominantly focus on

working at the individual level, an understanding of how the person relates to the systems they are in and how these systems impact on the person is typically considered and incorporated into therapy (i.e. there is commonly an appreciation of the influence of systems such as family, work, school etc. on the individual). There have even been attempts at integrating systemic elements more formally into other approaches (e.g. see Dummett 2005).

### **Couples, families and group therapy**

Whether the therapy is carried out with individuals, couples, family or groups, it often has its roots in one of the major modalities, whether it be cognitive behavioural (e.g. behavioural couples therapy, cognitive behavioural approaches to family therapy), psychoanalytic/psychodynamic (e.g. group analytic psychotherapy), or systemic (e.g. systemic family therapy). In terms of groups, the group can be where the intervention takes place, for example a psycho-educational group where people can learn about a specific presenting problem, talk about their difficulties and develop ways to better cope, or where being part of the group itself is the therapy. When it comes to deciding on whether a patient should be referred for individual, couples, family or group therapy, this should be guided by the assessment and formulation (i.e. which format is most suitable for the patient and their presenting problem), and the evidence regarding effectiveness and guidelines (this will be covered later in this paper). When deciding on which format to refer a patient to, it is crucial that the patients (service user) preference is always taken into consideration and wherever possible followed. In addition to individual, couples, family and group therapies, there are also therapeutic communities (Pearce *et al* 2017).

### **Distinct and Standalone Therapies**

A number of distinct and effective therapies have developed under the broad umbrella of the major modalities. For instance, stemming from psychoanalytic/psychodynamic roots is brief psychodynamic therapy (Leichsenring *et al* 2004), from cognitive and behavioural roots, dialectical behaviour therapy, acceptance and commitment therapy, and mindfulness based cognitive therapy (Oei & Dingle 2008; Ost 2008; Hacker *et al* 2016). Then there are therapies which draw on at least two of the major modalities, such as, cognitive analytic therapy, interpersonal therapy, schema focused therapy and mentalization-based therapy (Taylor *et al* 2017; Ali and Findlay 2016; Cristea *et al* 2017). There are also therapies that developed outside of the major modalities, for example, eye movement desensitization and reprocessing therapy, art therapies, as well as mindfulness based approaches unrelated to cognitive behavioural therapy, the latter of which have equivocal support but recent data suggests they appear that they could be promising evidence-based treatments (Goldberg *et al* 2017). Carr (2008) and Roth and Fonagy (2005) provide a good summary and review of many forms of psychological therapy.

### **Research evidence – what works and for whom**

There is evidence that most of the major psychotherapy approaches are effective for people presenting with a range of psychological problems (Carr 2008; Roth and Fonagy 2005). Evidence from randomised control trials and meta-analyses provide support for the effectiveness of the systemic approach (Shadish & Baldwin 2003), humanistic therapy

(Elliot *et al* 2013), existential therapy (Vos *et al* 2015), psychodynamic therapy (Leichsenring *et al* 2004) and cognitive behavioural therapy (Butler *et al* 2006).

However, while there is evidence that most of the major psychotherapy approaches are effective this does not mean that there is a ‘dodo bird verdict’, that is, there is not psychotherapy equivalence when it comes to outcomes. Some approaches are more effective than others when it comes to treating certain presenting problems. Additionally, given the nature of the scientific method, the evidence to support a form of psychotherapy is not static but changeable in light of accumulating data and how this data is selected and interpreted. A good example of this is provided by Johnsen and Friberg (2015) who presented a meta-analysis suggesting that cognitive behavioural therapy was becoming less effective, but Cristea *et al* (2017) argued that this was not the case, after they used a different and arguably more rigorous methodology, for example, they restricted their review to include only randomised controlled trials.

At present, there is compelling evidence that for certain problems some therapies are more effective than others. In the UK, the National Institute of Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) have carried out rigorous systematic reviews of the existing scientific literature and developed evidence-based guidelines for what therapies appear to be most effective for presenting problems commonly seen in clinic. We would recommend clinicians particularly those working in the UK, be familiar with this guidance and consult with these guidelines to determine which therapy to use depending on the presenting problem. NICE guidance has a wider breath of

guidance than SIGN, and provides good guidelines for many common presentations seen in clinic, including, generalised anxiety disorder, depression social anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder, eating disorders, personality disorders, psychosis/schizophrenia, and chronic fatigue syndrome. Some examples of the guidance are provided below.

NICE (2009a) guidance on treating depression in adults recommends several evidence-based psychological therapies. For mild to moderate depression, initially it is recommended that ‘low-intensity’ interventions be trialled which include, cognitive and behavioural guided self-help and computerised cognitive behaviour therapy. If this has not been effective, or if the patient has moderate to severe symptoms, then a ‘high-intensity’ intervention should be considered, such as, cognitive behavioural therapy, interpersonal therapy, behavioural couples therapy for those whose relationship may be contributing to or maintaining depression. For patients with mild to moderate depression who decline these therapies, it is recommended that one consider short-term psychodynamic psychotherapy. For psychosis in adults, if a person is considered to be at an increased risk of developing psychosis, cognitive behavioural therapy with or without family intervention should be offered, and for those people experiencing psychosis, cognitive behavioural therapy, family intervention, and art therapies are recommended (NICE 2014). There is encouraging evidence for dialectical behaviour therapy and mentalization-based therapy for borderline personality disorder (NICE 2009b; Ali and Findlay 2016). For post-traumatic stress disorder, cognitive behavioural therapy and eye movement desensitisation and reprocessing therapy are recommended (NICE 2005b). For social anxiety disorder,



individual cognitive behavioural therapy is recommended (specifically the Clark and Wells model or Heimberg model for adults) and for those who decline this, short-term psychodynamic psychotherapy that has been developed to treat social anxiety disorder should be considered. For obsessive compulsive disorder, cognitive behavioural therapy (including exposure and response prevention) is recommended. Cognitive behavioural therapy is also recommended for chronic fatigue syndrome (NICE 2007).

This is just a sample of the guidelines and what is evident is that there are certain therapies which, according to current evidence, are more effective for some presentations than others. Keeping up to date with the current guidance is important. For presenting problems not addressed by the guidelines the Cochrane Library is an excellent resource to consult.

### **Considering complexity: the shortcomings of guidelines and how to address this**

A number of important questions arise when using NICE and related guidance in clinical practice. We will consider here the three that are most often asked of us when discussing the topic. The first is, regardless of the presenting problem (e.g. depression, chronic fatigue), are there certain people who are more or less likely to benefit from psychological therapy? The second question is, what should one do when there is comorbidity given the guidelines are disorder specific? And related to this, thirdly, is it not best in complex cases to integrate therapies and/or tackle transdiagnostic processes (i.e. a symptom or problem based approach) to improve outcomes?

Firstly, in regard to whether there are certain people who are more or less likely to benefit from psychotherapy than others. While some research has been carried out in this area (e.g. Blenkiron 1999), there is presently insufficient evidence to make any firm recommendations. Therefore, it is important to consider and offer psychological therapy to all patients where evidence-based approaches exist to address the problems they are experiencing. However, it is of course imperative to adapt therapy to ensure it is developmentally appropriate and that it is tailored to the patient's intellectual ability and that sufficient support and motivation are provided to enhance engagement.

Regarding the second question of what should one do when there is comorbidity and complexity given the guidelines are disorder specific. Firstly, it should be acknowledged that because the guidelines are disorder specific this is a significant shortcoming when considering a therapy for someone with comorbid presentations. It invariably presents challenges given that the clinical reality is that comorbid and complex presentations are commonly seen in clinic.

There has been a growing unease in recent years about the validity and usefulness of diagnostic categories which the guidelines stem from. While we think it would be foolish to abandon the current diagnostic system because of shortcomings, and figuratively throw the baby out with the bath water, there does appear to be a need to modify the current system and perhaps a move towards a dimensional approach would be advisable. DSM 5 in spite of its many flaws has made efforts to incorporate the dimensional approach to diagnosis and classification, although these efforts have not been without criticism.

The clinical reality is that comorbidity and complexity is the norm and not the exception. Many clinicians reading this paper will regularly see patients with multiple diagnoses. It is arguable though that perhaps what we are looking at is not always truly multiple disorders but rather multiple symptoms which may have a common aetiology and/or are being maintained by common processes and as such the present diagnostic system and current guidelines don't always adequately address this.

However, even when there is complexity and comorbidity it is often possible to identify specific problems where NICE guidelines can be applied and effective therapies trialled that a patient may benefit from. Given the present diagnostic system as it stands, there is a necessity for impartial guidelines informed and guided by a rigorous scientific methodology that reviews the evidence to aid clinical decision making, and which ensures that where possible evidence-based therapies are provided to patients. At present, NICE and SIGN provide this function and their evidence-based guidelines are, within the existing parameters, fit for purpose.

There may be some clinicians reading this paper whose role when choosing a psychological therapy for their patient may be limited to assessing, diagnosing, developing a formulation, and then referring patients for treatment to appropriate specialist services. In these circumstances, in addition to having knowledge of local and national psychotherapy services that are able to provide the recommended therapy, it will probably be sufficient to be guided by NICE and SIGN guidelines. However, as we have highlighted the guidelines

can be found to be lacking when a patient presents with complexity and comorbid conditions. Referring to the Cochrane library might be of help here as well as discussing the case with colleagues who have expertise in psychological therapy.

We would argue that for those delivering psychological therapy it is important when assessing and formulating to see if it is possible to identify specific problems where NICE guidance could be followed. Therefore, if during the process of assessment and formulation it becomes apparent that there are specific well-defined problems present (e.g. a patient experiencing persistent panic attacks and depression as part of a complex trauma presentation) then serious consideration should be given to addressing the problems where guidance exists and following protocols as recommended by relevant guidelines and high-quality reviews (e.g. NICE and SIGN guidelines). In such a situation following treatment protocols and addressing presenting problems in a somewhat progressive manner may prove effective, for instance, addressing the most distressing or disabling problem first. This approach is echoed in the NICE guidelines. For example, in the NICE (2009) guidance for treating depression in adults it is recommended that when a patient presents with depression and symptoms of anxiety then the first priority should usually be to treat the depression, however, it is acknowledged that it might be more appropriate to treat the anxiety difficulties first, and doing so may likely improve depressive symptoms. When it comes to complex presentations where there is not clear guidance, for example, a patient referred with behavioural problems and disparate symptoms that do not fit diagnostic categories and where current guidelines are not available then taking a formulation driven and transdiagnostic approach may prove beneficial.

## **Formulation**

Formulation can aid in the understanding of a patient's difficulties, identify what may be contributing to, exacerbating, and/or maintaining problems, and help prioritise and select where to intervene (Butler 1998). As Mace and Binyon (2005) point out formulation can be carried out before commencing psychotherapy. It is not only a skill for clinical psychologists and psychotherapists, but is a key clinical skill for all psychiatrists. There are many different ways to formulate (for example, Johnstone and Dallos 2006). We would recommend that formulation be developed collaboratively with the patient and be what guides and informs intervention, and that the intervention should be evidenced-based and appropriate to addressing the presenting problem.

## **Transdiagnostic approach and psychotherapy integration.**

Taking a transdiagnostic approach (i.e. a symptom or problem based approach) may prove effective, particularly for complex presentations. A transdiagnostic approach involves examining for common factors which appear to contribute to and/or maintain symptoms and developing an idiosyncratic formulation of presenting difficulties to guide on where to intervene. Intervention can then address the cognitive, behavioural, interpersonal and social factors which appear to be exacerbating and/or maintaining symptoms (e.g. Barlow, 2010).

If assessment and formulation suggest there is a good rationale to consider integrating from a number of therapeutic approaches, there are a number of considerations to keep in mind when embarking on this approach. When one considers the psychotherapy approaches presented in this paper, it should be apparent that a complete integration between any or all

of these approaches would be a challenge. Epistemological incompatibilities abound, and distinct differences exist regarding how presenting problems are conceptualised and how interventions and treatment is carried out. In spite of these challenges, efforts have been made to combine and integrate approaches. This is in part because all psychotherapy approaches have both strengths and limitations and no single approach is suitable for all patients. Additionally, while there are many differences between therapies there are also similarities. That is, common factors do exist across psychotherapies.

A number of frameworks have been advanced to aid psychotherapy integration. These include, theoretical integration (integrating at the theory level), technical eclecticism (applying approaches that seem likely to be effective regardless of the theoretical underpinnings), and assimilative integration (having expertise in one form of psychotherapy and using this as a foundation while pragmatically drawing on and incorporating aspects from other approaches) (Norcross & Goldfried 2005). Assimilative integration has been considered a good theoretical and empirically based integrative approach (Lampropoulos 2001). Assimilative integration enables one to have a secure theoretical base, while then carefully selecting effective elements from other approaches.

However, before a clinician attempts an integrative approach, it is important that they have the sufficient knowledge, skills and competence, in at least one if not two psychotherapeutic approaches. Additionally, they should have developed a detailed formulation, and have a clear rationale for using an integrative approach. University

College London's online competence frameworks available at [www.ucl.ac.uk](http://www.ucl.ac.uk) is a useful resource to consult.

## **Conclusion**

Choosing the most suitable psychological therapy for a patient can sometimes be a challenge for clinicians. Recent advancements in the rigour of assessing which psychological therapies are most effective for specific conditions has made this decision making easier. Certain psychological therapies have been found to be more effective than other approaches. Consulting relevant guidelines and high-quality reviews, such as, those from the National Institute for Health and Care Excellence, Scottish Intercollegiate Guidelines Network, and the Cochrane Library is recommended before commencing treatment or referring a patient for psychological therapy. This should ensure that the patient will be provided with the most effective evidence-based therapy. If specific well-defined problems are present (e.g. panic disorder, obsessive compulsive disorder etc.) then consideration should be given to addressing these following protocols recommended by relevant guidelines and high-quality reviews.

With complex presentations, particularly featuring comorbidity, it may prove effective to take a parsimonious approach and treat the most distressing and/or disabling problem first (e.g. depression, social anxiety etc.), following treatment protocols and addressing presenting problems in a somewhat progressive manner. However, identifying underlying factors/processes and addressing these might prove to be more effective. What is crucial is the use of formulation. In all clinical work formulation is important but when any

complexity is present it is vital as it should be what guides and informs intervention (Johnstone, 2006). Intervention should where possible be evidenced-based and appropriate to addressing the presenting problem. Where indicated taking a transdiagnostic approach (i.e. examining for symptoms or common factors which appear to contribute to and/or maintain symptoms) and/or integrating therapeutic approaches may prove effective, however, caution and careful consideration is advised here for the novice therapist. For complex presentations, it would be best that only an experienced specialist in psychological therapy should treat the patient. If a less experienced therapist undertakes such work close clinical supervision from an experienced therapist is recommended.

When choosing a psychological therapy, in addition to assessment, formulation, and consulting guidelines, it is also important to consider patient preference, for example, some patients may prefer not to attend for a specific therapy or prefer to attend for individual therapy and not want to attend for group therapy. It is equally important that, in the absence of compelling evidence, patients are not excluded from being offered psychological therapy based on their history, background or diagnosis. Whatever therapy is chosen the routine monitoring of clinically relevant outcomes is recommended.



## Declaration of interest

TC is part funded by the Biomedical Research Centre for the South London and Maudsley NHS Foundation Trust and the Institute of Psychiatry. This organisation had no role in writing this manuscript or decision to submit. This paper received no specific grant from any funding agency, commercial or not-for-profit sector. TC has several grants evaluating the efficacy of different cognitive behavioral approaches.

DMc and TC are both practicing cognitive behavioral psychotherapists. TC was the President of the British Association of Behavioral and Cognitive Psychotherapies between 2012 and 2015.

## References

- Ali S, Findlay C (2016) A review of NICE guidelines on the management of Borderline Personality Disorder. *British Journal of Medical Practitioners*, 9, 1.
- Barlow DH, Farchione TJ, Fairholme CP, *et al* (2010) *Unified protocol for transdiagnostic treatment of emotional disorders*. Oxford University Press.
- Bateman A, Holmes J (2002) *Introduction to Psychoanalysis*. Routledge.
- Beck AT (1976) *Cognitive therapy and the emotional disorders*. Meridian.
- Beck AT (1993) Cognitive therapy: nature and relation to behavior therapy. *The Journal of psychotherapy practice and research*, 2, 342–356.
- Bion WR (1962) *Learning from Experience*. Heinemann.
- Blenkiron P (1999) Who is suitable for cognitive behavioural therapy? *Journal of the Royal Society of Medicine*, 92, 222–229.
- Breuer J, Freud S (1895) Studies on hysteria. In *The standard edition of the complete psychological works of Sigmund Freud* (eds J Strachey), Vol. 2. The Hogarth Press.
- Butler G (1998) Clinical formulation. In A.S. Bellack & M. Hersen (Eds.), *Comprehensive clinical psychology*. Pergamon.
- Butler AC, Chapman JE, Forman EM, Beck AT (2006) The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clinical Psychology Review*, 26, 17–31.
- Carr A (2008) *What Works with Children, Adolescents, and Adults*. Routledge.
- Clark DM (2011) Implementing NICE guidelines for the psychological treatment of

depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry*, 23, 318–327.

Cristea IA, Gentili C, Cotet C (2017) Efficacy of Psychotherapies for Borderline Personality Disorder: A Systematic Review and Meta-analysis. *JAMA Psychiatry*, 74, 319–328

Cristea IA, Stefan S, Karyotaki K, David D, Hollon SD, Cuijpers P (2017). The effects of cognitive behavioral therapy are not systematically falling. *Psychological Bulletin* 143, 3, 326–340.

Dummett N (2005) Processes for Systemic Cognitive-Behavioural Therapy with Children, Young People and Families. *Behavioural and Cognitive Psychotherapy*, 34, 179–189.

Ellis A (1962) *Reason and Emotion in Psychotherapy*, Citadel Press.

Elliott R, Watson J, Greenberg LS, Timulak L, Freire E (2013) Research on humanistic-experiential psychotherapies. In *Bergin & Garfield's Handbook of psychotherapy and behavior change* (Eds MJ Lambert) pp. 495–538. Wiley.

Freud S (1910) The Origin and Development of Psychoanalysis. *The American Journal of Psychology*, 21, 181–196.

Flaskas C (2005) Psychoanalytic ideas and systemic family therapy: revisiting the question ‘why bother?’. *Australian and New Zealand Journal of Family Therapy*, 26, 125–134.

Gabbard GO (2007) Major modalities: psychoanalytic/psychodynamic. In *Oxford Textbook of Psychotherapy* (eds GO Gabbard, JS Beck, J Holmes), pp. 3–13. Oxford University Press.

Goldberg SB, Tucker RP, Greene PA, Davidson RJ, Wampold BE, Kearney DJ, Simpson TL (2017) Mindfulness-based interventions for psychiatric disorders: A systematic review and meta-analysis. *Clinical Psychology Review*, <http://dx.doi.org/10.1016/j.cpr.2017.10.011>

Hacker T, Stone P, MacBeth A (2016) Acceptance and commitment therapy - Do we know enough? Cumulative and sequential meta-analyses of randomized controlled trials. *Journal of Affective Disorders*, 190, 551–565.

Horney K (1999) *Neurosis And Human Growth*. Routledge.

Johnstone L (2006). Controversies and debates about formulation. In L. Johnstone & R. Dallos (Eds.), *Formulation in psychology and psychotherapy: Making sense of people's problems* pp.208–231. Routledge.

Johnstone L, Dallos R (2006) *Formulation in psychology and psychotherapy: Making*

*sense of people's problems*. Routledge.

Janet P (1901) *The mental state of hystericals*. Putnam's Sons.

Jenkins H, Asen K (1992) Family therapy without the family: a framework for systemic practice. *Journal of Family Therapy*, 14, 1–14.

Johnson TJ, Friborg O (2015). The effects of cognitive behavioral therapy as an anti-depressive treatment is falling: A meta-analysis. *Psychological Bulletin*, 141, 747–768.

Klein M (1984) *Envy and Gratitude and Other Works 1946-1963*. The Hogarth Press.

Lampropoulos GK (2001) Bridging technical eclecticism and theoretical integration: Assimilative integration. *Journal of Psychotherapy Integration*, 11(1), 5–19.

Leichsenring F, Rabung S, Leibing E (2004) *The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: a meta-analysis*. *Archives of General Psychiatry*, 61, 1208-16.

Ma K (2006) Attachment theory in adult psychiatry. Part 1: Conceptualisations, measurement and clinical research findings. *Advances in Psychiatric Treatment*, 12, 440–449

Mace C, Binyon S (2005) Teaching psychodynamic formulation to psychiatric trainees. Part 1: basics of formulation. *Advances in psychiatric treatment*, 11, 416-423.

Minuchin S, Rosman BL, Baker L (1978) *Psychosomatic Families*. Harvard University Press.

Mowrer OH (1947) On the dual nature of learning—a re-interpretation of "conditioning" and "problem-solving." *Harvard Educational Review*, 17, 102-148.

NCCMH (2011) *Generalised Anxiety Disorder in Adults: Management in Primary, Secondary and Community Care*. The British Psychological Society and the Royal College of Psychiatrists.

NICE (2005a) Obsessive-compulsive Disorder: Core Interventions in the Treatment of Obsessive-compulsive Disorder and Body Dysmorphic Disorder. *NICE clinical guideline*, 31.

NICE (2005b) Post-traumatic Stress Disorder (PTSD): the Management of PTSD in Adults and Children in Primary and Secondary Care. *NICE clinical guideline*, 26.

NICE (2007) Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management. *NICE clinical guideline*, 53.

- NICE (2009a) Depression: the Treatment and Management of Depression in Adults. *NICE clinical guideline*, 90.
- NICE (2009b) D Borderline personality disorder: recognition and management. *NICE clinical guideline*, 78.
- NICE (2013) Social anxiety disorder: recognition, assessment and treatment. *NICE clinical guideline*, 159.
- NICE (2014) Psychosis and schizophrenia in adults: prevention and management. *NICE clinical guideline*, 178.
- Norcross JC, Goldfried MR (2005) *Handbook of Psychotherapy Integration*. Oxford University Press.
- Oei TPS, Dingle G (2008) The effectiveness of group cognitive behaviour therapy for unipolar depressive disorders. *Journal of Affective Disorders*, 107, 5–21.
- Ost, LG (2008) Efficacy of the third wave of behavioral therapies: A systematic review and meta-analysis. *Behaviour Research and Therapy*, 46, 296–321.
- Patton MJ, Meara NM, Robbins SB (1992) *Psychoanalytic counseling*. John Wiley & Sons.
- Pavlov IP (1927) *Conditioned reflexes*. Oxford University Press.
- Pearce S, Scott L, Attwood G, Saunders K, Dean M, DeRidder R, Galea D, Konstantinidou H, Crawford M (2017) Democratic therapeutic community treatment for personality disorder: randomised controlled trial. *The British Journal of Psychiatry*, 210, 149-156.
- Power M, Brewin CR (1991) From Freud to cognitive science: a contemporary account of the unconscious. *British Journal of Clinical Psychology*, 30, 289-310.
- Rogers C (1951) *Client-centered therapy*. Constable.
- Roth A, Fonaghy P (2005) *What works for whom?* Guildford Press.
- Shadish WR, Baldwin SA (2003) Meta-analysis of MFT interventions. *Journal of Marital and Family Therapy*, 29, 547-570.
- Spinelli E (2014) *Practising Existential Therapy*. Sage.
- Stratton P (2011) *The evidence base of systemic family and couples therapies*. Association for Family Therapy, UK.
- Taylor CDJ, Bee P, Haddock G (2017) Does schema therapy change schemas and

symptoms? A systematic review across mental health disorders. *Psychology and Psychotherapy: Theory, Research and Practice*, 90, 456-479.

Tarrier N, Johnson J (2015) *Case Formulation in Cognitive Behaviour Therapy*, Routledge.

Vos J, Craig M, Cooper M (2015) Existential therapies: A meta-analysis of their effects on psychological outcomes. *Journal of Consulting and Clinical Psychology*, 83, 115–128.

Watson JB, Rayner R (1920) Conditioned emotional reactions. *Journal of experimental psychology*, 3, 1–14.

Wolpe J (1968) Psychotherapy by reciprocal inhibition. *Conditional reflex*, 3, 234–240.

Q1) All psychological therapies are equally effective for treating obsessive-compulsive disorder

1. Yes, that's true
2. No, the evidence is that existential therapy works best
3. A systemic approach is recommended by NICE as the first line psychological therapy
4. Cognitive behavioural therapy is the most effective psychological therapy for OCD
5. Cognitive behavioural therapy is most effective when combined with psychoanalytic therapy

- Answer = 4

Q2) The therapeutic relationship is not that important for psychotherapy to be effective

1. This is true, it is not that important in modern psychological therapies
2. It is only a concern for psychoanalytic/psychodynamic and humanistic approaches
3. It is crucial to pay attention to and foster the therapeutic relationship as it is central to effective psychological therapy
4. It is only important to consider if the patient is not engaging well in therapy
5. It is of little importance in cognitive behavioural therapy

- Answer = 3

Q3) A transdiagnostic approach is a recommended approach for complex cases

1. It is likely to be particularly suitable for complex cases and when comorbidity is present
2. Only to be used when there is no evidence of comorbidity
3. It should never be used
4. A transdiagnostic approach can be used for anxiety disorders but not depression
5. It is only suitable for emotional problems and not persistent and unexplained physical symptoms

- Answer = 1

Q4) Short-term psychodynamic therapy is the most effective therapy for treating social anxiety disorder

1. Yes, that's true
2. No, the evidence is that short-term psychodynamic therapy is not at all effective
3. No it is not, existential therapy is recommended by NICE as the most clinically effective and cost-effective psychological therapy

4. It is not the most effective but is more effective than the Clark and Wells model of cognitive therapy
  5. It is effective but cognitive behavioural therapy is more effective, particularly the Clark and Wells model or Heimberg model
- Answer = 5

Q5) Systemic approaches should never be integrated with other approaches

1. That is well supported by the available evidence
  2. Only with humanistic and existential approaches as they are epistemologically compatible
  3. Only with psychoanalytic/psychodynamic approaches as they are epistemologically compatible
  4. Most major therapeutic modalities incorporate systemic elements implicitly or explicitly, and there have even been attempts to formally incorporate it with other approaches
  5. Elements can be integrated with most approaches except cognitive behavioural therapy
- Answer = 4